EXHIBIT 61

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

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IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION
MDL No. 2804
Case No. 17-md-2804
Judge Dan Aaron Polster

This document relates to:

The County of Cuyahoga v. Purdue Pharma L.P., et al.
Case No. 18-OP-45090

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Videotaped deposition of
THOMAS GILSON, M.D.
30(b)(6)

January 14, 2019
9:07 a.m.

Taken at:
Climaco, Wilcox, Peca & Garofoli
55 Public Square, Suite 1950
Cleveland, Ohio

Renee L. Pellegrino, RPR, CLR

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review. So this paper mentions some things from 2013, but I think the gist of the bulk of it is about the 2012 review that we did in the office.
Q. The paper referring to Exhibit 10, right?
A. Exhibit 10, yes.
Q. Okay. Fair enough.
The next bullet point there under the Heroin Epidemic title is "2013 prospective review of heroin mortality done with ME staff," et cetera, et cetera, right?
A. Right. We assembled people within the room at the ME's office in a committee that I called together to review that data, and the goal was -- for example, in law enforcement we had the sheriffs there, a county officer. He had a representative who could provide information to us, partly on arrests but mostly on incarceration data, because what we were trying to do in this was to identify intervention points, and one of the risk factors for fatal overdose was somebody who was coming out of incarceration or a treatment facility. So that was kind of the makeup of this.
Q. So if you go to the next page, we're

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talking about a set of 194 overdose fatalities, right?
A. Right.
Q. And that's 2013, right?
A. Right.
Q. And then if you go three more pages, it says, "PDR Findings." It looks like that (indicating).
A. Yes.
Q. It says here 73 percent of heroin overdose victims had a file with OARRS, right?
A. Right. About three-fourths.
Q. Now, we've also seen that number, 73 percent, in other documents associated with you or your office. And when we see that, 73 percent of heroin overdoses who had an OARRS file, that refers to this 2013 data set, right?
A. Right.
MR. BORANIAN: I'm told the phone isn't working. I'm not sure what to do about that.
MR. GALLUCCI: I think that's probably from before when we heard it right before we took a break.
MR. BORANIAN: Okay. Let's take a

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break, but if you could indulge me, don't go away, Doctor.
THE VIDEOGRAPHER: Off the record at 3:09 p.m.
(Short recess had.)
THE VIDEOGRAPHER: Back on the record at 3:10 p.m.
BY MR. BORANIAN:
Q. This is Exhibit 12. Oops. I marked the wrong one. Hang on.
- - - - -
(Thereupon, Gilson Deposition Exhibit 12, Document Entitled "Opioid Crisis Response: Examining Overdose Deaths at Cuyahoga County Medical Examiner's Office," with Attached Sheet Bates Numbered CUYAH_001684555 - Marked Confidential, was marked for purposes of identification.)
- - - - -
Q. This is Exhibit 12, Dr. Gilson. This appears to be a presentation, or maybe a poster, with your name on it, along with Dr. Deo. Can you tell us what this is, Doctor?

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A. I'm not completely certain, but I think this was a poster that Dr. Deo, who is a student at the Case Western School of Public Health, produced based on research he was doing at our office.
Q. So it's entitled "Opioid Crisis Response: Examining Overdose Deaths at Cuyahoga County Medical Examiner's Office," with a Bates number noted on the second page as 001684555, and if you look over at the far right column, Doctor, it says, "OARRS Data, Fentanyl Overdose Deaths February 2017," right?
A. Right.
Q. Is this part of the analysis of fentanyl deaths in connection with OARRS that you've described before?
A. Yes.
Q. It says, "55 fentanyl overdose deaths in February 2017," right?
A. That was one of the worst months in Cuyahoga County, yes.
Q. And the fourth bullet point says that 41 out of 55 had an OARRS file, right?
A. That's correct.
Q. That's about 80 percent, right?

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A. Yes.
Q. Now, you've mentioned earlier in the deposition that same number, 80 percent. Is this the source for your citation of the 80 percent figure?
A. No.
Q. Okay. Has the medical examiner's office done any analysis of fentanyl overdose deaths other than what's represented here on Exhibit 12?
A. Yes, we have.
Q. What is the source of your stated opinion that 80 percent of fentanyl deaths have a history of prescription medication?
A. It's this information. I thought you said 80 percent of our opioid deaths, heroin deaths.
Q. Maybe I misspoke. I'm sorry, Doctor. I haven't looked at the transcript, but I think you said earlier today that 80 percent of fentanyl deaths have a recent history or a history of a prescription drug prescription, right?
A. No. What I said earlier today was that approximately 80 percent of the heroin

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overdose deaths that we had in that phase of the crisis had an OARRS file, and that was the 73 percent that I'm referencing here.
Q. Okay. So that's where I'm confused then. Okay. So what I was seeing for heroin deaths is 64 percent based on the 2012 retrospective data.
A. Sure.
Q. I have seen 73 percent based on the 194 cases in 2013. Doctor, where do you get 80 percent of heroin-related deaths have an OARRS file?
A. Sure.
My estimate, if I might say, is that we estimated approximately 80 percent of the heroin overdose victims had a history of receiving prescription pain relievers. I take that from this data, the 73 percent. And I'm not parsing that for, you know, this is closer to what I want.
The 2012 data, where the 66 percent came from, was actually limited in the time of look-back because we had delay in getting access to OARRS to do the look-back. So some of the look-backs we did on heroin overdoses in 2012

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were as short as six months and, at the longest, 18 months. So I thought that number -- and this was one of the reasons I wanted to continue to collect the data -- was potentially an underestimate.
When I saw this number, this still actually represents, to some extent, a, you know, initial period look-back of about two years for virtually all of these cases in 2013. That was a better look-back period.
Q. Let me stop you there. When you say "this number," which number?
A. 73 percent.
Q. Okay. Continue.
A. Is better data, and that's really what we were striving to get to see if we could tie the heroin crisis back to opioid pain relievers.
At the time we were collecting this data, there was really very little, other than anecdotal reports, to say this heroin phase of the crisis represented a transition.
In 2013 substance abuse and mental health services published a bulletin, where they had gone back and talked to actual heroin users

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and said, "How did you get started abusing opioids," and that number was 79.5 percent, 80 percent of those addicts said I started using opioid pain relievers. And when they looked the other direction, most of the people who were abusing opioid pain relievers said no, I never started with heroin, I'm abusing this substance.
So when I saw that number in conjunction with this -- and this is again as more data is becoming involved -- that's where I draw that number of about 80 percent of our addicted population come from that transition. I can't talk to the people after they died to ask them how did you get started, but somebody did that, we didn't duplicate that effort, but we used this data as a support to that to say, listen, almost 80 percent of our overdoses have been using prescription opioids, some of them with very long track records and, in fact, you know, that number is very close to what's being quoted from the interviews with the living individuals who are abusing heroin currently.
Q. The 80 percent, then, comes from a bulletin that you read, right?
A. From the substance abuse and mental

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health services.
Q. Have you reviewed the data upon which they base that bulletin?
A. Yes, I did.
Q. And what form did that data take?
A. They're interviewing heroin addicts, current heroin addicts, with the question that I said, you know, how did you get started abusing opioids, and 80 percent, 79.5 percent said that they had started abusing prescription medications.
Q. Did those interviews take into account whether those individuals had a prescription for the opioid that they say they initiated with?
A. They talked about non-medical pain reliever use. I do not know that I remember enough detail to say whether they had, in fact, obtained those legally or by diversion.
Q. So you can't tell from those data whether the use of prescription opioids was legal or illegal for that population, true?
A. I don't remember exactly the -- what that metric was.
The other thing I wanted to add --

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Q. They didn't ask about that in their survey, did they?
A. Pardon?
MR. BADALA: Were you done?
Q. They didn't ask about that in their survey, did they?
A. Could I finish the previous thought, though?
Q. Sure.
A. The other thing I wanted to add about that study is they did a ten-year look-back. Basically they wouldn't trust the addict's memory beyond ten years, so they were looking back further than we were with our data. So I thought that might have explained some of the smaller discrepancy, the 73 percent versus the 79 percent, but statistically they were very close.
Q. In what form was that data provided to you?
A. What data was that?
Q. The data that supported the bulletin that you reviewed. You said you reviewed the data. In what form was it?
A. I reviewed the bulletin. I didn't

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go back to review the original research data. I didn't understand you if that was what you were saying.
Q. Okay. My question was if you had reviewed the data, so I'll ask again.
Did you review the original research data for that bulletin?
MR. BADALA: Objection to form. Outside the scope.
A. No. I reviewed the bulletin and the methods that were spelled out in it.
MR. BADALA: Do you have to take a break or anything?
THE WITNESS: Sure. Okay.
MR. BADALA: Why don't we take a five-minute break.
THE VIDEOGRAPHER: Off the record at 3:19 p.m.
(Recess had.)
THE VIDEOGRAPHER: Back on the record at 3:26 p.m.
BY MR. BORANIAN:
Q. So, Dr. Gilson, we've been discussing the investigation of diversion and overprescription and the use of the OARRS

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database. Has the county made any other uses of the OARRS database beyond what we've already discussed?
MR. BADALA: Objection to form.
Q. Not just your office, the whole county.
A. We're obviously sharing our data at these task forces, including the data that we've gleaned from OARRS -- by "we" in this case, I'm putting on my medical examiner hat -- and impacts that could have on law enforcement, prosecutions, things like that. I can't necessarily quantitate, but the collaborative effort that we created I think with this data and pointing it back towards opioid pain relievers I think is kind of a ripple effect of using the OARRS system.
Specifics in terms of using the OARRS system, I'm aware some jurisdictions use it to identify doctors to sign death certificates. We have not done that.
Q. Do you know who the OARRS registrants are within the county, people who actually have an OARRS access set of credentials?

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A. Within the county itself?
Q. Yes.
A. As county representatives or just the whole county?
Q. As representatives of the county, for example, the sheriff's office or protective services or the medical examiner.
A. I would know that the physicians at the county hospital would all have OARRS access because that was actually part of an initiative in 2015, to have all of the medical practitioners have access to OARRS, and then I think the pharmacists are similar, that they have to have access, so I would think pharmacy personnel at our county hospital would have that; jail, by extension, as we covered that, would have access. And we in the medical examiner's office. The sheriff, unless it's through a law enforcement, which I'm not aware of -- I don't know if they do or do not. Other law enforcement agencies I believe do, but they're not county representatives.
Q. Does the county sheriff ever directly access the OARRS database?
A. I do not know. I don't know. As I

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said, they have access. They can have access through law enforcement.
Q. So other than your office, are you aware of any other county office that makes direct access to the OARRS database?
A. Oh, I'm sorry if I wasn't clear. The county hospital has to have that access with its practitioners and its pharmacy.
Q. Anyone else? Any other agencies?
A. Can I look at the org chart? I can't see anybody here I could say with certainty has access.
Q. Is there any database or central file system for cases investigating drug diversion?
MR. BADALA: Objection to form.
A. At the county level or --
Q. Yes.
A. Unless it's in the county prosecutor's office, I'm not aware of one. I know they have a unit who would be investigating cases for prosecution, but otherwise, most of the investigation of diversion and things like that I think would be at a state level.
Q. Is there any central database or

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file system for county investigations of overprescribing of medicine?
A. Again, at our county hospital, with the office of opioid affairs that was opened, they review prescribing practices with opioid pain relievers with the idea of addressing apparent overprescribing with practitioners that they identify.
Q. When a physician is under investigation for participating in illegal diversion, does the county take steps to stop the behavior during the investigation?
A. Are we talking -- I'm a little confused -- pill mill scenario or something like that or --
Q. Yeah, any doctor under investigation, whether a county employee or someone running a pill mill, someone running a pain clinic. If that doctor is under investigation, does the county take any steps to stop the illegal activity while the investigation is going on?
A. I mean, ultimately they would arrest them, I guess, if they were founded in the evidence collection period. I guess until you

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really know that it's a crime --
Q. Short of arresting somebody, is anything done to stop the behavior that is under investigation?
A. If I can go back to the county hospital, the example with the office of opioid affairs there, yes, they are liaisoned with -- through the medical staff and the practices are described. And I don't think it's an immediate you're doing the wrong thing so much as they require an explanation, and if that explanation isn't satisfactory, then they're remediated to, you know, prescribing practices, maybe reacquaintance with CDC prescribing guidelines from 2016 or something like that as a basis.
Q. Now, Doctor, I'm also going to ask you about topic number 27, which is "Knowledge of and access to data concerning prescription opioid manufacturing, prescribing, distribution, or dispensing." We've already gone through ARCOS and OARRS and a few others. I'm not going to repeat that.
So here's my question, Doctor: Are there other databases that the county could use to gain information about the manufacturing,

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they were intending to purchase and what they got.
Q. How does the county define an epidemic?
MR. BADALA: Objection to form. Outside the scope.
A. With the standard definition, which is an elevated prevalence of a disease beyond its baseline in a community.
Q. So when you were talking about cocaine and the doubling of deaths between, I think it was -- you said it was 2015 and 2016?
A. Right. Yes.
Q. So do you consider that doubling a cocaine epidemic?
MR. BADALA: Objection to form. Outside the scope.
A. No, for the reason that I am -- that I mentioned, which is that when you factor out the opioid contribution to that elevation, it's not at an increased incidence over baseline.
Q. Would you consider the number of deaths in 2016 where cocaine was adjudicated and certified as the cause of death, is that a crisis for Cuyahoga County?

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MR. BADALA: Objection to form. Outside the scope.
A. I mean, we were in the midst of an opioid crisis before that. Certainly there was an acute worsening in 2016 that was driven by -- primarily by fentanyl. That's the position of the county. The fact that cocaine was pulled back up with that, heroin was pulled back up with that doesn't negate the contribution of fentanyl to that part of the crisis.
Q. So I'm trying to understand, with respect to cocaine specifically, does the county consider itself to be in the middle of a cocaine crisis?
MR. BADALA: Objection to form. Outside the scope.
A. We're in the middle of a drug crisis. I mean, is cocaine up from where it was, yes, and I think the strategy is all of the above with the drugs. But if you're asking me is the elevation in cocaine significant relative to the elevation of the opioids, I would say that it's less, because what our data shows in the mortality data is that the elevation in the cocaine is, unfortunately, being pulled up by

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fentanyl.
Q. So before the cocaine doubled between '15 and '16, that previous baseline level of cocaine abuse and death, do you consider -- does the county consider the 2014 level of cocaine abuse and use to be a crisis in and of itself?
MR. BADALA: Objection to form. Outside the scope.
A. It's an area of concern. If you're asking me is it a crisis because it's acutely worsened, the answer to that is no.
Q. So my question is if -- well, how many deaths were there in 2014 caused by cocaine?
A. I can check. 124.
Q. Does Cuyahoga County consider 124 deaths to be a crisis?
MR. BADALA: Objection to form.
A. I'm sorry. You know, we're not turning our back on these folks. All of these things are sad, that these people are dying, and I think, you know, the overshadowing of this crisis by heroin, fentanyl is just more tragic, but if you're asking me are these folks any less

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valuable or something, like no. That's not a position. The county is concerned about all of our citizens, and these 124 folks who died of a cocaine overdose are just as much, you know, missed by their people as the hundreds who died of a fentanyl or heroin overdose.
Q. So from the county's perspective, the 124 deaths in 2014, the county would consider those to be a crisis for cocaine?
MR. BADALA: Objection to form. Outside the scope.
A. I mean, as you use the term "crisis," I think of that in terms of the epidemic, and that is not part of the epidemic, but it's a source of great concern. We don't like to see our citizens die of any drug overdose, but -- maybe we're parsing over words, but, you know, the crisis is really the opioids, it's not the cocaine here, but that doesn't mean that it's not a source of tremendous concern.
Q. What did Cuyahoga County do in 2014 or the years that followed to address the use and abuse of cocaine that resulted in 124 deaths in 2014?
A. The county would have continued its

drug treatment services. The county would have made available things like the START program to those parents. It wasn't like we exclusively, you know, excluded them. So we would connect those parents with cocaine issues, with, you know, a mentor in recovery. The county would have responded to separate families where there potentially was an issue that wasn't resolvable with cocaine. I think the county, you know, continued its treatment efforts. Drug court didn't shut cocaine people out. It's just that the docket became much more tilted towards opioids.

Q. Is that everything you can identify sitting here today the county did in response to the cocaine use and abuse in 2014?

A. If I can look at our organizational chart again.

During that time period, around 2013, 2014, the sheriff's office instituted strike forces. They were supposed to supplement local law enforcement so that they could address any multitude of issues. So it could have been in part, you know, drug trafficking. Re-entry programs obviously were making efforts to

reintegrate cocaine addicts. Workforce development. Prosecutions of drug dealers by our county prosecutor. The creation of drug court for the treatment of drug addicts in lieu of incarceration, provision of mental and medical health services in the county jail.

Q. Does the county --

A. There's a lot of things --

Q. I'm sorry.

A. I'm sorry. I just wanted to sort of close it.

This problem touches so many levels of our community, and I think, you know, interventions for some of these things are not necessarily just we shut the door on everything except the opioids. We're trying to deal with all of them, and I don't want to say that I could be exhaustive. I think as I run through our org chart, there's a lot of things I can see there.

Q. From the county's perspective, is the use and abuse of methamphetamine at crisis level?

MR. BADALA: Objection to form. Outside the scope.

A. Again, you know, with what I've said about crisis, I would say no, it hasn't really escalated to the comparabilities of like being similar to heroin or, especially now, fentanyl.

Q. Has the county done everything in its power to combat the abuse of the illegal drugs identified in topic 18?

A. I think the county has made significant investments to do that. I think if you ask me are there more things we wish we could do, we do. But there's -- you know, as much as we can do, I really feel, especially our models of collaboration, cooperation -- they're national models now, and I do feel that this has really been a very exemplary response to this crisis, both this one and the opioid crisis especially.

Q. You talked earlier in the day about Mexican cartels and China with respect to illicit fentanyl. Do you recall that topic generally?

A. I remember mentioning China, and I think the person who was asking me at the time mentioned Mexico, and that's part of the story I think as well.

Q. Do you agree that the importation of heroin and illicit fentanyl from other countries into the county could be considered an act of terrorism?

MR. BADALA: Objection to form. Outside the scope.

Which topic are we on?

MR. CARTER: We're on 34.

MR. BADALA: If you could just indicate that.

A. I think I made that statement.

Q. You've made that statement. I'm asking does the county agree with it.

A. I wouldn't want to necessarily put that as the county's position. It's a personal opinion. I don't know that I have independent confirmation to say that.

Q. Okay. In terms of the drivers of the rapid increase in mortality in the county from 2010 through to today, do you agree that it's been heroin, illicit fentanyl, fentanyl analogs and cocaine since 2010?

MR. BADALA: Objection to form.

A. Sure. I mean, I think that, you know, you can look at this page from Exhibit 13,

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which goes up to 2012. Here's our crack cocaine. There's our prescription opioids. Here's the heroin phase. And if you want to go back to our own charts and graphs, the fentanyl phase was even worse than the heroin escalation. The analogs of fentanyl that we saw, carfentanil, the elephant tranquilizer, those other drugs, all caused significant rises in mortality, and like the opioid pain relievers, heroin, fentanyl, they are illicit opioids that act on the same mechanism in the brain that the opioid pain relievers do.

Q. So I think we're on the same page, but just to be clear then, from 2010 through to today the primary drivers of the increase in mortality in the county have been heroin, illicit fentanyl, fentanyl analogs and cocaine, true?

A. Again, I'd have to put the caveat with cocaine that, by itself, it hasn't dramatically changed, and that the changes that we see in cocaine can be reasonably attributed to fentanyl, as can the changes after 2016 with heroin, but heroin, in the time frame you mentioned, is a significant game changer from

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2012, 2011 onward.

Q. I want to follow up on some questions on topic 19. You talked about the criteria. I'm not going to go through all that again, but I want to focus on the criteria, the third one you identified, people that have been diagnosed with an opioid use disorder, okay?

How does the county define an opioid use disorder?

A. The county identified that in consultation with experts beyond what I'm prepared to talk about today.

Q. So sitting here today, can you give me a scientific or a layperson definition that the county used to define opioid use disorder or did you defer to the experts on that?

A. I believe we deferred to the experts on that.

Q. Related, does the county have an official working definition of addiction that it used to identify individuals in response to Exhibit A and Exhibit B that are part of Deposition Exhibit 2?

A. I'm not aware of a working definition the county has for addiction.

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Q. Do you agree that a diagnosis of addiction is a medical task?

MR. BADALA: Objection to form.

A. I mean, the addiction has a definition in medicine.

Q. And there are physicians who provide medical diagnoses of addiction, correct?

MR. BADALA: Objection to form. Outside the scope.

A. I don't know if I would say addiction versus substance use or abuse disorder. It's an area of medicine, the terminology of which I am not familiar and I would not think the county would have an opinion on.

Q. Do you know whether there are ICD-10 codes to define a substance use disorder?

MR. BADALA: Objection to form. Outside the scope.

A. ICD-10?

Q. Yes.

A. I don't think the county knows that. I don't know it myself.

Q. Do you know what ICD codes refer to generally?

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A. Sure. Sure do. I do I should say. The county may not, but the International Classification of Diseases. As their agent, I would be able to inform them of that.

Q. Do you agree that, from a medical perspective, it's inappropriate to assume a use disorder or an addiction, however you want to use that term -- you would need to look at an individual case, an individual resident story to arrive at a conclusion of a use disorder or addiction, right?

MR. BADALA: Objection to form. Outside the scope.

A. Yeah. That's a medical diagnosis again and I don't think the county would express anything about the appropriateness of misclassifying that.

Q. So the county has never -- well, the county has never used its medical examiner data or any other data set that it creates and assigned classification of a use disorder or an addiction based on looking at that data set, correct? That's nothing the county has ever done before?

MR. BADALA: Objection to form.

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A. The medical examiner data would not arrive at those diagnoses. The alcohol, drug addiction and mental health services of the county would arrive at diagnoses like that. The hospital could arrive at diagnoses like that. Does the county itself, you know, oversee that diagnosis? No.
Q. You agree that all use -- substance use disorders can be treated, correct?
MR. BADALA: Objection to form. Outside the scope.
A. That's a question outside my area of expertise.
Q. So you do not know whether the county is able to treat substance use disorders for any substance they might classify?
MR. BADALA: Objection to form. Outside the scope.
A. As I understood your question, all substance use disorders being treatable, I don't know that that's something that I could say the county has an opinion on.
Q. What about, does the county agree that, with appropriate support, all addicted individuals can make a recovery?

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MR. BADALA: Objection to form. Outside the scope.
A. I think the county would like to give all those addicted individuals that opportunity. Whether or not they can recover would be beyond really the scope of the county's ability to predict that.
Q. Do you agree that there are a number of people who take prescription opioids and do not develop an opioid use disorder?
MR. BADALA: Objection to form. Outside the scope.
A. Again, without having a definition of an opioid use disorder, I could only say that the long-term use of opioids would be expected over time to create dependence on them and physical withdrawal symptoms when they were removed. Whether that moves into addiction or not, I couldn't really say.
Q. Do you agree there are a number of people who take prescription opioids and never go on to break the law?
MR. BADALA: Objection to form. Outside the scope.
A. I would sure hope so.

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Q. Are there people who have an opioid use disorder from prescription opioids who do not go on to use illegal narcotics?
MR. BADALA: Objection to form. Outside the scope.
Which topic are we on?
MR. CARTER: Topic 19, "The criteria used to identify individuals who overdosed on, or became addicted to, prescription opioids."
MR. BADALA: Objection to form. Outside the scope.
A. Now you guys made me lose the question.
Q. Sure.
The question was, are there people who have an opioid use disorder from prescription opioids who nonetheless do not go on to use illegal narcotics?
MR. BADALA: Same objections.
A. I think national data would support that and probably local data, that there were people prescribed who did not go on to become addicted.
Q. With respect to topic 19, has the county itself vetted or confirmed any individual

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diagnosis of an opioid use disorder?
A. That information was submitted to the experts for their interpretation. The county did not independently vet those experts. They were referred to our attorneys and they consulted with the experts.
Q. In connection with compiling the individuals identified on Exhibit A, did the county conduct any interviews of those individuals?
A. We identified claims data with the criteria that I've mentioned, and that was submitted through to our attorneys, and then they conferred with experts and responded to the interrogatories. To my knowledge, the county did not conduct independent interviews after that referral.
Q. After that information was referred to the attorneys and the experts, do you know if the attorneys or the experts interviewed the individuals listed on Exhibit 2, sub-Exhibit A? It's the oversized printout.
A. It's the big one, right?
Q. Yes.
MR. BADALA: And I would just